IOWA WHOLESALE DRUG LICENSE APPLICATION

Please type or print clearly. Make changes as necessary.

1 APPLICATION FOR: ☐ New ☐ Renewal ☐ Change _____
(please specify)

IOWA WHOLESALE DRUG LICENSE NO.:

EXPIRATION DATE:

LICENSE FEE: $270.00

2 NAME & MAILING ADDRESS where all correspondence regarding licensure will be sent if other than licensed location below.

Name _____

Address _____

_____

_____

City,State,Zip _____

Remit check or money order payable to:
IOWA BOARD OF PHARMACY

(DO NOT SEND CASH)

Every wholesale distributor, wherever located, who engages in wholesale distribution into, out of, or within Iowa must be licensed by the Board before engaging in wholesale distribution of prescription drugs or devices. Where operations are conducted at more than one location by a single wholesale distributor, each such location shall be licensed by the Board.

3 LEGAL NAME AND LICENSED LOCATION ADDRESS

Name _____

Address _____

_____

_____

City,State,Zip _____

IOWA COUNTY _____

4 BUSINESS PHONE (____) _____

5 EMERGENCY CONTACT PHONE AT LICENSED FACILITY (___) _____

6 BUSINESS FAX (____) _____

7 RESPONSIBLE CONTACT PERSON AT LICENSED FACILITY (Manager in charge)

Name: _____ Title: _____

8 E-MAIL ADDRESS _____

9 INTERNET ADDRESS _____

---

10 DESCRIPTION OF OPERATIONS

Please attach a complete typewritten description of the licensed facility operations including:

a. Your type and hours of operation, i.e. wholesale distribution only, manufacturer, repackager, distribution center, chain pharmacy distribution center, reverse distributor, durable medical equipment supplier, medical gas distributor, blood center, importer/exporter, logistics provider, etc.

b. ALL types of prescription drugs, devices, or medical gases that you distribute or market, i.e. DEA controlled substances (please identify Schedule II, III, IV, or V), ephedrine or pseudoephedrine products (Iowa Schedule V controlled substances), noncontrolled prescription drugs ("federal legend"), veterinary prescription drugs, durable medical equipment (legend devices), medical gases, blood or blood products, over-the-counter drugs, etc.

c. ALL types of customers you sell or distribute to, i.e. other wholesalers, hospitals, pharmacies, practitioners (Medical Doctors, Dentists, Veterinarians, Optometrists, etc.), patients/end users, etc.

11 TYPE OF OWNERSHIP OR OPERATION

☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Other _____
(please specify)

12 OWNER/OPERATOR OF THE FACILITY 1) If a person: the name and address of the person; 2) if a partnership: the name of each partner and the name and address of the partnership; 3) if a corporation: the name and title of each corporate officer and director, the corporate names, name and address of the parent company, if any, and the State of incorporation; 4) if a sole proprietorship: the name of the sole proprietor and the name and address of the business entity. Attach additional sheets if necessary.

_____

_____

_____

13 Have any of the applicant(s) and/or manager(s) in charge had: 1) any convictions relating to the distribution of drugs (including samples); 2) any felony convictions; 3) any suspension or revocation of licensure for the manufacture or distribution of drugs by federal, state, or local laws of any license currently or previously held by the applicant(s) or manager(s) in charge in any of the United States? Have any applications for licensure been denied by any federal or state agency? List and explain. Attach additional sheets if necessary.

_____

_____

14 All trade or business names ("DBA" names) used by corporation or licensee. If none, indicate such.

_____

_____

15 List all other states where licensed for wholesale drug or device distribution. If none, indicate such.

_____

_____

16 HOME STATE Provide the following information for the state in which the facility is located. If any of the information is not applicable, please indicate N/A.

State: _____ License No.: _____ Expiration Date: _____ DEA No.:_____

State Controlled Substance License No.: _____ FDA No. (manufacturers only): _____

17 IF HOME STATE IS NOT IOWA Attach a copy of the most recent Home State Board of Pharmacy or Department inspection report for this facility. Explain if not available.

REMIT TO: IOWA BOARD OF PHARMACY
400 S.W. EIGHTH STREET, SUITE E
DES MOINES, IA 50309-4688
PHONE: (515) 281-5944

Information provided on this application may be disclosed pursuant to 657 IAC Chapter 14.

I hereby swear under penalty of perjury that the information provided in this application is true and correct. I understand that failure to provide complete and truthful information may constitute grounds for denial, revocation, or other disciplinary sanctions against my license.

SIGN HERE _____ _____ _____
Signature of Owner or Corporate Officer *Title* *Date*

INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED AND WILL BE RETURNED TO APPLICANT